

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4845AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2009
NAME OF PROVIDER OR SUPPLIER HORIZON ASSISTED LIVING 1		STREET ADDRESS, CITY, STATE, ZIP CODE 920 LEAVITT LANE MESQUITE, NV 89027		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on 5/12/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for eight Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The facility received a grade of A.</p> <p>No regulatory deficiencies were identified. No further action is necessary. Please retain a copy of this report for your records.</p>	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE